MASTER GROUP CONTRACT

BETWEEN

CITY OF BLOOMINGTON

AND

MEDICA INSURANCE COMPANY

MEDICA INSURANCE COMPANY (“MEDICA”)

MASTER GROUP CONTRACT

ARTICLE 1
INTRODUCTION

This Master Group Contract ("Contract") is entered into by and between Medica Insurance Company ("Medica") and the employer group identified in Exhibit 1 ("Employer"). This Contract includes Exhibit 1, Exhibit 2, Exhibit 3, the Group Application, Member enrollment forms, the Certificate of Coverage (“Certificate”) and any Amendments, all of which together shall constitute the entire agreement between Medica and Employer converning the health insurance coverage provided under this Contract. This Contract includes the coverage option(s) set forth in Exhibit 2 and Exhibit 3, offered by the Employer under a single group health plan. This Contract is delivered in the state of Minnesota.

The capitalized terms used in this Contract have the same meanings given to those terms defined in the Certificate, unless otherwise specifically defined in this Contract.

If this Contract is purchased by Employer to provide benefits under an employee welfare benefit plan governed by the Employee Retirement Income Security Act, 29 U.S.C. 1001, et seq. (“ERISA”), this Contract is governed by ERISA and, to the extent state law applies, the laws of the State of Minnesota. If this Contract is not governed by ERISA, it is governed by the laws of the State of Minnesota. If this Contract is governed by ERISA, any legal action arising out of or relating to this Contract shall be brought in the federal district court for the district of Minnesota. If this Contract is not governed by ERISA, any legal action arising out of or relating to this Contract shall be brought in state court in Hennepin County, Minnesota.

In consideration of payment of the Premiums by the Employer and payment of applicable Deductibles, Copayments and Coinsurance by or for Members, Medica will provide coverage to Members for the Benefits set forth in the Certificate and any amendments, subject to all terms and conditions, including limitations and exclusions, in this Contract.

This Contract replaces and supersedes any previous agreements between Employer and Medica relating to Benefits.

Medica shall not be deemed or construed to be an employer for any purpose with respect to the administration or provision of benefits under Employer’s welfare benefit plan. Medica shall not be responsible for fulfilling any duties or obligations of Employer with respect to Employer’s benefit plan.

ARTICLE 2
TERM OF CONTRACT

Section 2.1 Term and Renewal. The initial Term of this Contract is set forth in Exhibit 1.

At least 30 days before the end of each coverage year, Medica shall notify Employer of any modifications to this Contract, including Premiums and Benefits for the next year of this Contract (“Renewal Terms”). If Employer accepts the Renewal Terms or if Employer and Medica agree on

different Renewal Terms, this Contract is renewed for an additional coverage year, unless Medica terminates this Contract pursuant to Section 2.2.

Section 2.2 Termination of This Contract. Employer may terminate this Contract after at least 30 days written notice to Medica. This Contract is guaranteed renewable and will not be terminated by Medica except for the following reasons and such terminations will be effective as stated below. Except as specified otherwise, terminations for the reasons stated below require at least 30 days written notice from Medica:

(a) Upon notice to an authorized representative of the Employer that Employer failed to pay the required Premium when due, provided, however, that this Contract can be reinstated pursuant to Section 5.2. If Employer fails to pay the required Premium within the grace period described in Section 5.2, the Contract will be terminated, subject to a 30-day advance written notice of termination by Medica to Employer. The date of the termination shall be retroactive to not more than 30 days prior to the effective date of the notice of termination;

(b) On the date specified by Medica because Employer committed fraud (through act, practice or omission) or intentionally provided Medica with false information material to the execution of this Contract or to the provision of Benefits under this Contract. Medica has the right to rescind this Contract back to the original effective date;

(c) On the date specified by Medica due to Employer's violation of the participation or contribution rules as determined by Medica;

(d) Automatically on the date Employer ceases to do business pursuant to 11 U.S.C. Chapter 7;

(e) Automatically on the date Employer ceases to do business for any reason;

(f) On the date specified by Medica, after at least 90 days prior written notice to Employer, that this Contract is terminated because Medica will no longer issue this particular product within the large employer market;

(g) On the date specified by Medica, after at least 180 days prior written notice to the applicable state authority and Employer, that this Contract will be terminated because Medica will no longer renew or issue any employer health benefit plan within the large employer market;

(h) Automatically on the date that Employer fails to maintain any active employees who are Subscribers;

(i) Any other reasons or grounds permitted by the licensing laws and regulations governing Medica.

Notwithstanding the above, Medica may modify the coverage for a new coverage year and may modify the Premium rates in a manner consistent with Section 5.5 of this Contract. Nonrenewal of coverage as a result of failure of Medica and the Employer to reach agreement with respect to modifications in the Premium rate or coverage shall not be considered a failure of Medica to provide coverage on a guaranteed renewable basis.

Section 2.3 Notice of Termination.

Medica will notify Employer in writing if Medica terminates this Contract for any reason.

In accordance with applicable law, Medica will notify Subscribers in writing if Medica terminates this Contract pursuant to Section 2.2(a), (b), (d), (f) or (g).

Employer will provide timely written notification to Subscribers in all circumstances for which Medica does not provide written notification to Subscribers.

Section 2.4 Effect of Termination. In the event of termination of this Contract:

(a) All Benefits under this Contract will end at 12:00 midnight Central Time on the effective date of termination;

(b) Medica will not be responsible for any Claims for health services received by Members after the effective date of the termination; and

(f) Employer shall be and shall remain liable to Medica for the payment of any and all Premiums that are unpaid at the time of termination.

ARTICLE 3
ENROLLMENT AND ELIGIBILITY

Section 3.1 Eligibility. The Eligibility conditions stated in Exhibit 1 of this Contract govern who is eligible to enroll under this Contract. The eligibility conditions stated in Exhibit 1 are in addition to those specified in the Certificate.

Section 3.2 Enrollment. The Certificate governs when eligible employees and eligible dependents may enroll for coverage under this Contract, including the Initial Enrollment Period, Open Enrollment Period and any applicable Special Enrollment Periods. Employer shall conduct the Initial Enrollment Period and Open Enrollment Period. Employer shall cooperate with Medica to ensure appropriate enrollment of Members under the Contract.

Section 3.3 Qualified Medical Child Support Orders. Employer will establish, maintain and enforce all written procedures for determining whether a child support order is a qualified medical child support order as defined by ERISA. Employer will provide Medica with notice of such determination and a copy of the order, along with an application for coverage, within the greater of 30 days after issuance of the order or the time in which Employer provides notice of its determination to the persons specified in the order.

When and if Employer receives notice that the child has designated a representative, or of the existence of a legal guardian or custodial parent of the child, Employer shall promptly notify Medica of such person(s).

Medica shall have no responsibility for:

(i) establishing, maintaining or enforcing the procedures described above;

(ii) determining whether a support order is qualified; or

(iii) providing required notices to the child or the designated representative.

Section 3.4 Eligibility and Enrollment Decisions. Subject to applicable law and the terms of this Contract, Employer has discretion to determine whether employees and their dependents are eligible to enroll for coverage under this Contract. Medica is entitled to rely upon Employer's determination regarding an employee's and/or dependent's eligibility to enroll for coverage under this Contract. The Employer will be responsible for maintaining information verifying its continuing eligibility and the continuing eligibility of its eligible Subscribers and eligible Dependents. This information shall be provided to Medica as reasonably requested by Medica. The Employer shall also maintain written documentation of a waiver of coverage by an eligible Subscriber or eligible Dependent and provide this documentation to Medica upon reasonable request.

Section 3.5 Notification. The Employer must notify Medica within 30 days of an individual's initial enrollment application, changes to a Member's name or address, changes to a Member's eligibility for coverage (including a loss of eligibility) or other changes to enrollment.

Section 3.6 Multiple Benefit Package Options. Subscribers and enrolled Dependents may only switch between Employer's health coverage options offered under the Contract during a Special Enrollment Period, or the Open Enrollment Period, if applicable, as described in the Certificate.

ARTICLE 4
PREMIUMS

Section 4.1 Monthly Premiums.

The initial monthly Premium rates for this Contract are set forth in Exhibit 2.

The Premiums are due on the **first** day of each calendar month. Employer shall pay the Premiums to Medica in accordance with the method set forth in the invoice.

Employer shall notify Medica in writing:

(a) each month of any changes in the coverage classification of any Subscriber; and

(b) within 30 days after the effective date of enrollments, terminations or other changes regarding Members.

Section 4.2 Grace Period and Reinstatement. Employer has a grace period of 10 days after the due date stated in Section 5.1 to pay the monthly Premiums. If Employer fails to pay the Premium, the Contract will be terminated in accordance with Section 2.2(a). This Contract will be reinstated if Employer pays all of the Premiums owed on or before the end of the grace period. In the event this Contract is not reinstated pursuant to this Section, Medica shall not be responsible for any Claims for health services received by Members after the effective date of the termination.

Section 4.3 Premium Calculation. The monthly Premiums owed by Employer shall be calculated by Medica in accordance with Exhibit 2 using the number of Subscribers in each coverage classification according to Medica's records at the time of the calculation. Subject to Section 5.4,

Employer may make adjustments to its payment of Premiums for any additions or terminations of Members submitted by Employer but not yet reflected in Medica's calculations.

A full calendar month's Premiums shall be charged for Members whose effective date falls on or before the 15th day of that calendar month. No Premium shall be charged for Members whose effective date falls after the 15th day of that calendar month. With the exception of termination of coverage due to a Member's death, a Member's coverage may be terminated only at the end of a calendar month and a full Premium amount for that month will apply. In the case of a Member's death, that Member's coverage will be terminated on the date of death.

Section 4.4 Retroactive Adjustments. In accordance with applicable law and this Contract, retroactive adjustments may be made for addition of Members, changes in Members' coverage classifications, and certain terminations of Members not reflected in Medica's records at the time the monthly Premiums were calculated by Medica. Employer understands and acknowledges that federal law prohibits the retroactive termination of a Member's coverage except in instances of fraud, intentional misrepresentation of material fact, or failure to timely pay premiums or premium contributions. Employer agrees that it will not request retroactive termination of any Member's coverage if such termination is prohibited by law. Notwithstanding the foregoing, no retroactive credit will be granted for any month in which a Member received Benefits. No retroactive adjustments to enrollment or Premium refund shall be granted for any change occurring more than 60 days prior to the date Medica received notification of the change from Employer.

Notwithstanding the foregoing, Employer shall pay a Premium for any month during which a Member received Benefits (except as described in Section 5.3).

Section 4.5 Premium Changes. The Premium rates under this Contract are guaranteed for a 12 month period following the Effective Date of this Contract, provided that the Premium rates may be increased by the amount charged by Medica for any additional Benefits required by applicable state and/or federal law as reflected in a Regulatory Amendment. Additionally, notwithstanding the foregoing, the rate guarantee will not apply and Medica may change the Premium rate if any of the following occur:

(a) the number of Subscribers increases or decreases by more than 15% from the enrollment that was estimated by the parties in conjunction with the January 1, 2015 renewal date and used as the basis for the rate calculation and guarantee;

(b) the average contract size (the ratio of number of Members to number of Subscribers) or average family size (the ratio of number of Members with family rated coverage to number of Subscribers with family rated coverage) increases or decreases by more than 5% from the average contract size and the average family size estimated by the parties in conjunction with the January 1, 2015 renewal date and used as the basis for the rate calculation and guarantee;

(c) Employer refuses to include in its health plan design standard changes approved by the State for inclusion in Medica's health plans;

(d) there are any regulatory, benefit or tax changes that would impact costs, as reasonably determined by Medica;

(e) Employer changes its benefit design in a manner that increases costs, as reasonably determined by Medica; or

(f) Employer seeks bids for its health plan.

The monthly Premium rates for the second coverage year of this Contract (January 1, 2016 through December 31, 2016) shall not increase by more than an average of 15% over the monthly premium rates applicable in 2015 (referred to hereafter as "the 2016 Premium Rate Cap"). Notwithstanding the foregoing, the 2016 Premium Rate Cap shall not apply if any of the situations set forth in (a) – (f) above occur.

Section 4.6 Employer Fees. Medica may charge Employer:

(a) a late payment charge in the form of a finance charge of 12% per annum for any Premiums not received by the due date; and

(b) a service charge for any non-sufficient-fund check received in payment of the Premiums; and

(c) an administrative service fee of $250.00 at time of request for reinstatement.

Section 4.7 Premium Rebate Administration (When Applicable).

(a) General Obligation. In accordance with the Patient Protection and Affordable Care Act ("PPACA"), Medica is obligated to provide a premium rebate to Employer if Medica's medical loss ratio ("MLR") for the group market applicable to Employer's coverage does not meet or exceed the minimum percentage required by PPACA for such group market. PPACA requires Medica to make such determinations on a calendar year basis, regardless of the Effective Date and Expiration Date of this Contract. For purposes of this Section 5.7, "medical loss ratio" shall be defined in accordance with PPACA and the group market size applicable to Employer's coverage shall be determined in accordance with PPACA's MLR provisions and applicable state law and requirements.

(b) Rebate Determinations and Remittances. Medica agrees to determine whether such rebates are owed under this Contract and, if applicable, remit such rebates to Employer within the timeframe required by applicable law.. Notwithstanding the foregoing, in the event that Employer's group health plan has been terminated at the time rebate payment is due and, despite reasonable efforts, Medica is unable to locate Employer, Medica will distribute the entire rebate to Subscribers, in accordance with applicable law.

(c) Form of Rebates. Medica may, in its sole discretion, elect to provide any such rebates owed in the form of a premium credit, a lump-sum check, or a lump-sum credit to the account used to pay the premium.

(d) Employer's Responsibility Concerning Rebates. Employer agrees that it is Employer's responsibility to determine how to treat any rebate funds remitted to Employer by Medica in accordance with applicable law, including but not limited to 45 C.F.R. §158.242 and ERISA requirements. Additionally, in no way limiting the foregoing, if Employer's group health plan is not a governmental plan and is not subject to ERISA, Employer agrees that Employer shall use the amount of any rebate that is proportionate to the total amount of premium paid by all Subscribers for the coverage in a manner that benefits Subscribers and is specifically provided in 45 C.F.R. §158.242(b)(1) and (2).

ARTICLE 5
INDEMNIFICATION

Medica will hold harmless and indemnify Employer against any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by Employer, including reasonable attorney fees and costs, that arise out of Medica's negligent acts or omissions in the discharge of its responsibilities to a Member.

Employer will hold harmless and indemnify Medica against any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by Medica, including reasonable attorney fees and costs, that arise out of Employer's or Employer's employees', agents', and representatives' negligent acts or omissions in the discharge of its or their responsibilities under this Contract.

Employer and Medica shall promptly notify the other of any potential or actual claim for which the other party may be responsible under this Article 6.

ARTICLE 6
ADMINISTRATIVE SERVICES

The services necessary to administer this Contract and the Benefits provided under it will be provided in accordance with Medica's or its designee's standard administrative procedures. If Employer requests such administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, and if Medica agrees to provide such non-standard administrative services, Employer shall pay for such services or reports at Medica's or its designee's then-current charges for such services or reports.

ARTICLE 7
CLERICAL ERROR

A Member will not be deprived of coverage under the Contract because of a clerical error. Furthermore, a Member will not be eligible for coverage beyond the scheduled termination date because of a clerical error, such as a failure to record the termination.

ARTICLE 8
ERISA

When this Contract is entered into by Employer to provide benefits under an employee welfare benefit plan governed by ERISA, Medica shall not be named as and shall not be the plan administrator of the employee welfare benefit plan, as that term is used in ERISA. Medica shall only be considered a named fiduciary for purposes of claims adjudication.

The parties agree that Medica has sole, final, and exclusive discretion to:

(a) interpret and construe the Benefits under the Contract;

(b) interpret and construe the other terms, conditions, limitations and exclusions set out in the Contract;

(c) change, interpret, modify, withdraw or add Benefits without approval by Members; and

(d) make factual determinations related to the Contract and the Benefits.

For purposes of overall cost savings or efficiency, Medica may, in its sole discretion, provide services that would otherwise not be Benefits. The fact that Medica does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

Medica may, from time to time, delegate discretionary authority to other persons or entities providing services under this Contract.

ARTICLE 9
DATA OWNERSHIP AND USE

Information and data acquired, developed, generated, or maintained by Medica in the course of performing under this Contract shall be Medica's sole property. Except as this Contract or applicable law requires otherwise, Medica shall have no obligation to release such information or data to Employer. Medica may, in its sole discretion, release such information or data to Employer, but only to the extent permitted by law and subject to any restrictions determined by Medica.

ARTICLE 10
CONTINUATION OF COVERAGE

Medica shall make available coverage under this Contract to those Members who are eligible to continue coverage as required under federal or state law.

Medica will not provide any administrative duties with respect to Employer's compliance with federal or state continuation of coverage laws. All duties of the Employer, including, but not limited to, notifying Members regarding federal and state law continuation rights and Premium billing and collection, remain Employer's sole responsibility.

ARTICLE 11
SUMMARY OF BENEFITS AND COVERAGE

Medica will prepare a Summary of Benefits and Coverage ("SBC"), as described under the Patient Protection and Affordable Care Act ("PPACA") and related regulations, for each coverage option set forth in Exhibit 2 and offered by Employer. Medica will provide applicable SBCs to Employer. Employer will distribute such SBCs to individuals eligible for and covered under Employer's group health plan in accordance with applicable federal regulations.

ARTICLE 12
NONDISCRIMINATION AND EMPLOYER SHARED RESPONSIBILITY

To the extent in accordance with the Patient Protection and Affordable Care Act ("PPACA"), fully-insured group health plans other than grandfathered plans are subject to nondiscrimination rules similar to those applicable to self-insured health plans under Section 105(h) of the Internal Revenue Code. Medica assumes no responsibility for compliance with such rules. Employer, as the sponsor of the insured employee benefit plan, shall be responsible for ensuring compliance with any and all PPACA nondiscrimination requirements applicable to the insurance coverage, including but not limited to payment of any and all governmental or regulatory taxes, penalties, interest, or other charges resulting from noncompliance with applicable nondiscrimination requirements. Employer, as the sponsor of the insured employee benefit plan, is solely responsible (1) for determining whether, with respect to its employee workforce, the aspects of a particular insurance contract are discriminatory under PPACA, and (2) for appropriately addressing the situation if it is discriminatory under PPACA (including but not limited to correcting, self-reporting, and payment of any penalties and interest related to the discrimination).

PPACA added employer shared responsibility provisions as Section 4980H of the Internal Revenue Code, under which an applicable large employer (as defined in Section 4980H) may be subject to assessable payments in the event the employer fails to offer affordable coverage providing minimum value to its full-time employees and their dependents and at least one full-time employee is allowed a premium tax credit for coverage purchased through an insurance exchange created pursuant to PPACA. PPACA also requires that applicable large employers satisfy related information reporting requirements. The effective date of the employer shared responsibility requirements and related information reporting requirements are as prescribed by the federal government. Employer is solely responsible for ensuring compliance with PPACA's employer shared responsibility provisions and related requirements, including but not limited to (1) determining the full-time/part-time status of its employees; (2) communicating eligibility and enrollment information to Medica, in accordance with Article 3 of this Contract; (3) determining Employer and employee contributions to the payment of premium; (4) satisfying all information reporting requirements applicable to applicable large employers; and (5) paying any and all assessable payments, penalties, interest, or other charges resulting from noncompliance with the employer shared responsibility provisions and related requirements.

ARTICLE 13
AMENDMENTS AND ALTERATIONS

Section 13.1 Standard Amendments. Except as provided in Section 13.2, amendments to this Contract are effective 30 days after Medica sends Employer a written amendment. Unless regulatory

authorities direct otherwise, Employer's signature will not be required. No Medica agent or broker has authority to change this Contract or to waive any of its provisions.

Section 13.2 Regulatory Amendment. Medica may amend this Contract to comply with requirements of state and federal law ("Regulatory Amendment") and shall issue to Employer such Regulatory Amendment and give Employer notice of its effective date. The Regulatory Amendment will not require Employer's consent and, unless regulatory authorities direct otherwise, Employer's signature will not be required. Any provision of this Contract that conflicts with the terms of applicable federal or state laws is deemed amended to conform to the minimum requirements of such laws.

ARTICLE 14
ASSIGNMENT

Neither party shall have the right to assign any of its rights and responsibilities under the Contract to any person, corporation or entity without the prior written consent of the other party; provided, however, that Medica may, without the prior written consent of the Employer, assign the Contract to any entity that controls Medica, is controlled by Medica, or is under common control with Medica. In the event of assignment, the Contract shall be binding upon and inure to the benefit of each party's successors and assigns.

ARTICLE 15
DISPUTE RESOLUTION

In the event that any dispute, claim or controversy of any kind or nature relating to this Contract arises between the parties: if acceptable to both parties, the parties will meet and make a good faith effort to resolve the dispute. The party requesting the meeting will provide the other, in advance of the meeting, with written notice of the claimed dispute. Upon receipt of the written notice, representatives for each party will meet promptly to attempt to resolve the dispute. If a mutually agreeable resolution is not reached within thirty (30) days following receipt of the written notice, or if the parties do not agree to meet to attempt to resolve the dispute, either party may pursue legal action in accordance with the terms of this Contract. The parties may mutually agree to waive the informal dispute resolution process set forth herein. Any such waiver must be in writing and executed by both parties.

ARTICLE 16
PROVISIONS ON CERTAIN DEFENSES

All statements made by Employer shall, in the absence of fraud, be deemed representations and not warranties. No statement made by employer shall be used in defense to a claim under the Contract unless such statement is in writing. No statement made by Employer, except a fraudulent statement, shall be used to void this Contract after it has been in force for a period of 2 years.

ARTICLE 17
RELATIONSHIPS

The relationship between Employer and any Member is that of Employer and Subscriber, Dependent or other coverage classification as defined in this Contract.

The relationships between Medica and Network Providers and the relationship between Medica and Employer are **solely** contractual relationships between independent contractors. Network Providers and Employer are not agents or employees of Medica. Medica and its employees are not agents or employees of Network Providers or Employer.

The relationship between a Network Provider and any Member is that of provider and patient and the Network Provider is solely responsible for the services provided to any Member.

ARTICLE 18
EMPLOYER RECORDS

Employer shall furnish Medica with all information and proofs that Medica may reasonably require with regard to any matters pertaining to this Contract. Medica may at any reasonable time inspect all documents furnished to Employer by an individual in connection with the Benefits, Employer's payroll records, and any other records pertinent to the Benefits under this Contract.

Unless Employer provides the appropriate written assurances required by 45 CFR 164.504, Medica will only provide Employer with summary health information (for the purposes of obtaining premium bids or for modifying, amending or terminating the group health plan only) and information on whether individuals are participating in the group health plan, or is enrolled in or has disenrolled from the health plan as provided in 45 CFR 164.504 (f)(1) and the minimum necessary information for purposes of auditing Medica's operations or services.

ARTICLE 19
NOTICE

Except as provided in Article 2, notice given by Medica to an authorized representative of Employer will be deemed notice to all Members.

All notices to Medica shall be sent to the address stated in the Acceptance of Contract. All notices to Employer shall be sent to the persons and addresses stated in the Group Application. All notices to Medica and Employer shall be deemed delivered:

(a) if delivered in person, on the date delivered in person;

(b) if delivered by a courier, on the date stated by the courier;

(c) if delivered by an express mail service, on the date stated by the mail service vendor; or

(d) if delivered by United States mail, 3 business days after date of mailing.

A party can change its address for receiving notices by providing the other party a written notice of the change.

ARTICLE 20
COMMON LAW

No language contained in the Contract constitutes a waiver of Medica's rights under common law.

ARTICLE 21
ACCEPTANCE OF CONTRACT

This Contract is deemed accepted by Employer upon the earlier of Medica's receipt of Employer's first payment of the Premium or upon Employer's execution of this Contract by its duly authorized representative. This Contract is deemed accepted by Medica upon Medica's deposit of Employer's first payment of the Premium. Such acceptance renders all terms and provisions herein binding on Medica and the Employer.

IN WITNESS WHEREOF, Medica has caused this Contract to be executed on 1stth January,2015, to take effect on the Effective Date stated in Exhibit 1 to this Contract.

MEDICA INSURANCE COMPANY
401 Carlson Parkway
Minnetonka, MN 55305
(952) 992-2200

Billing Address:
NW 7958
P.O. Box 1450
Minneapolis, MN 55485-7958

Mailing Address:
P.O. Box 9310
Minneapolis, MN 55440

By:

Paul R. Crowley

Vice President and General Manager, Client Retention and Growth

By:

James P. Jacobson

Senior Vice President and Assistant Secretary

EMPLOYER

City of Bloomington

Address:
1800 West Old Shakopee Road
Bloomington, MN 55431

By: _____

Title: _____

Date: _____

EXHIBIT 1

1. **Parties.** The parties to this Master Group Contract ("Contract") are Medica Insurance Company ("Medica") and the employer group City of Bloomington ("Employer"), an employer under Minnesota law and other applicable law.

2. **Effective Date and Expiration Date of this Contract.** This Contract is effective from 01/01/2015 ("Effective Date") to 12/31/2015 ("Expiration Date"). All coverage under this Contract begins at 12:01 a.m. Central Time.

3. **Amendment(s) Number:** Amendments attached as applicable for benefit package log (BPL) as listed in Exhibit 2.

4. **Eligibility.** The following conditions are in addition to those specified in the Certificate:

4.1 Eligibility to Enroll.

A Subscriber, and his or her Dependents who satisfy the eligibility conditions stated in this Contract are eligible to enroll for coverage under this Contract. Any person who does not satisfy the definition of Subscriber or Dependent is not eligible for coverage under this Contract.

A Subscriber and his or her Dependents must meet the eligibility requirements described below and in the entire Contract.

4.2 Subscriber Definition, Waiting Periods and Coverage Effective Dates

Employees. An employee eligible to enroll under the Contract as a Subscriber must be an individual who:

(1) Satisfies either (a) or (b) below:

(a) Is employed on average for at least 30 hours per week by Employer. Employer shall determine the average number of hours worked and Medica is entitled to rely on Employer's representation in this regard;
(b) For Employers utilizing documented measurement and stability periods (as described in federal law) to determine an employee's eligibility for coverage: Is an employee who Employer determines eligible for coverage throughout the applicable stability period; provided that such determination is consistent with federal law applicable to such eligibility determinations and other applicable provisions of this Contract; and

(2) Satisfies the Employer participation and eligibility requirements, including, but not limited to, the satisfactory completion of a Waiting Period as described below.

Coverage for Subscribers will include the conditions identified below:

Classifications and Plan Design	Waiting Period and Coverage Effective Date
1. Employees:	New Hires: After 30 days of continuous employment Status Change: Same as new hire Return: Date of return Rehire: Same as new hire

Employer shall impose a uniform Waiting Period on all otherwise eligible employees, as described herein. Any such Waiting Period shall be calculated in compliance with the applicable provisions of PPACA and any and all regulations and guidance issued pursuant to PPACA, including but not limited to 29 C.F.R. §2590.715-2708 and 45 C.F.R. §147.116 and shall in no event exceed 90 days. Employer acknowledges that any desired change to applicable Waiting Periods or other provisions of this Contract concerning employee eligibility require prior notice to Medica and a mutually agreeable amendment to the Contract. Employer shall calculate the appropriate effective date of coverage for each employee and inform Medica of such date. Medica is entitled to rely on Employer's representation here in that the effective date of coverage does not violate the applicable provisions of PPACA or any regulations or guidance issued pursuant to PPACA.

EXHIBIT 2[k1]

Premiums

The monthly Premium rates for MIC PP MN 1500-20% HRA, group number(s) 69907, 69916, 69925, BPL #13620 are:

Single	$503.54
Employee + 1	$1,049.24
Family	$1,539.72

The monthly Premium rates for MIC ME/MES MN 1500-20% HRA,group number(s) 69910, 69913, 69919, 69922, 69928, 69931, BPL # 13621 are:

Single	$463.61
Employee + 1	$965.54
Family	$1,416.80

The monthly Premium rates for MIC PP MN 350-30-20%, group number(s) 69906, 69915, 69924, BPL #87197 are:

Single	$633.63
Employee + 1	$1,320.84
Family	$1,938.70

The monthly Premium rates for MIC ME/MES MN 350-30-20%, group number(s) 69909, 69912, 69918, 69921, 69927, 69930, BPL #87198 are:

Single	$583.19
Employee + 1	$1,215.42
Family	$1,783.86

EXHIBIT 3

Wellness Programming

For purposes of this Exhibit 3, *Eligible Member* means Members age 18 and over.

(a) **My Health Rewards Enhanced Program.** Medica will provide a value-based benefit program that emphasizes member engagement and personalization. The program is based on a behavior-based model that encourages and motivates members to make better health care decisions. Each Eligible Member is eligible to earn points for completion of specific activities, and to earn financial rewards for achievement of specified point totals. My Health Rewards Enhanced program also includes detail reporting, platform messaging, and biometric screenings administered by an affiliated program provider. Program components are subject to modification from time to time at Medica's sole discretion. The points-based wellness program may include the following components.

(1) A personal health assessment.

(2) Online digital coaching.

(3) An online activities tracking component.

(4) Biometric Screening – biometric screenings are coordinated through an approved vendor partner.

(5) Health Map – An online individualized portal where Eligible Members track their participation in and completion of Medica's health and wellness program, Medica health management programs that apply to the Eligible Member, and Employer-sponsored health and wellness programs.

(6) Fit Choices by Medica[SM] Program – Medica's standard fitness program, designed to reward Eligible Members who exercise regularly (a minimum of eight times per month) at participating fitness centers.

(7) Medica's standard health and wellness programs, as determined by Medica in its sole discretion.

(b) Employer agrees to pay Medica for the wellness programs and support services described in this Exhibit 3 as follows: $3.00 per Subscriber per month. Such amounts are included in the premium rates set forth on Exhibit 2.

(c) Medica will provide a Health Management Team that will consist of representatives from Health Strategy and Consulting and Strategic Account Management. The team will be responsible for health management program oversight, claims analysis, recommendations related to plan design changes or health management programming. The Health Management Team will attend semi-annual meetings with the Benefits Sub-committee of the Citywide Labor Management Committee.

(d) To the extent that all or part of Medica's wellness programming is a health-contingent wellness program as defined under applicable federal law, Employer is solely responsible for the following:

(1) Ensuring that any financial rewards Employer provides to Eligible Members for completion of the wellness program comply with federal law.

(2) Ensuring that materials prepared and distributed by Employer that describe the terms of the wellness program, and any disclosure that an individual did not satisfy an initial outcome-based standard, contain all required notices, including but not limited to the availability of a reasonable alternative standard to qualify for the reward and how to request one from Employer; that recommendations of an individual's personal physician will be accommodated; the possibility of waiver of a standard if applicable; and that completion of the wellness program is voluntary.

(3) Determining whether to grant an Eligible Member's request for a waiver of a health-contingent wellness program requirement.

(4) Communicating to Medica the Employer's decision to waive a health-contingent wellness program requirement.

(5) Responding to Eligible Member requests for a reasonable alternative standard.

Employer agrees that Medica has no liability for Employer's failure to comply with the provisions of this paragraph.